

Health Policy Newsletter

Volume 16 Number 4

December, 2003

Article 1

From the Editor Seeking Middle Ground

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Suggested Citation:

Nash DB. From the editor: Seeking middle ground. *Health Policy Newsletter* 2003; 16(4): Article 1. Retrieved [date] from <http://jdc.jefferson.edu/hpn/vol16/iss4/1>.

From the Editor

Seeking Middle Ground

As a medical educator and practicing primary care general internist at our academic medical center, I have probably attended literally hundreds of pharmaceutical company-sponsored lunches and grand rounds over the course of the last 14 years. No doubt, I have received scores of pens and pads branded with the names of dozens of different proprietary pharmaceutical products. I have probably collected hundreds of similar items walking the exhibit halls at major national medical meetings over a dozen years.

As a result of my behavior, many current observers would say that I have an inherent conflict of interest vis-à-vis the pharmaceutical industry and my work as a clinician. Evidence does support the fact that the pharmaceutical industry has contributed more than 60 percent of the total national support for continuing medical education (CME) on an annual basis.¹ Does this make *all* of CME suspect? I would like to explore this perception of a conflict of interest and seek middle ground amongst the cacophony of shrill voices demonstrating their tightly held beliefs across the spectrum of viewpoints in this arena.

Our current environment is poisoned by a slew of recent adverse publicity with regard to these perceived conflict of interest issues. *The Boston Globe* ran a front-page story this past summer detailing the recent investigations by the U.S. Attorney's Office in Boston.² These federal investigators are sending subpoenas to top academic medical centers, and elsewhere in the country, for records about their relationships with drug makers as part of a widespread crackdown on pharmaceutical company marketing practices. Federal prosecutors, according to the *Globe*, are looking into whether drug companies have been using these grants, in some cases, to try to influence doctors at leading hospitals to prescribe their medications to patients. If true, such behavior would be illegal under federal anti-kickback laws and may play a role in skyrocketing prescription drug costs.²

This *Boston Globe* story was then amplified in the medical press with a detailed piece in *Modern Healthcare*.³ Nationally prominent physician leaders such as Jordan Cohen, MD, the president of the Association of American Medical Colleges (AAMC), and others, were asked to give their views. Predictably, and appropriately, the AAMC supports its longstanding view that there needs to be a very careful arms-length relationship, if any relationship, between academic medical centers and the pharmaceutical industry. At nearly the same time, the popular news program *Dateline NBC* featured a summer headline-getting segment entitled "Drug Giant Accused of False Claims."⁴ In this July 2003 story, a scientist from Warner Lambert confessed, "It was my responsibility to leverage the trust that physicians had with pharmaceutical companies to corrupt the relationship between the physician and the patient." He specifically admitted to participating in activities promoting off-label use of certain neurologic medications.

Contemporaneously, Dana and colleagues, writing in the *Journal of the American Medical Association*, cite extensive social science research supporting their contention that individuals, even professionals, are often unable to avoid bias even

when it is in their best interest to do so.⁵ They contend that physicians will deny and succumb to bias, even when explicitly instructed about it, which suggests to them that self-serving bias is unconscious. Furthermore, they believe that even small gifts, those in keeping with current guidelines published by the Accreditation Council on Continuing Medical Education (ACCME), can subtly bias how arguments are evaluated, and they can be surprisingly influential. They call for an outright ban on all gifts to physicians regardless of size or scope. Even some of our most influential leaders have repeatedly called for a complete separation between the marketing and educational functions of large pharmaceutical companies.⁶ Is there a middle ground in this controversy, and what constructive efforts might we undertake to promote that middle ground?

Recognizing the scope and depth of this national .conflict of interest. debate, I am happy to report that Jefferson Medical College has created an operational framework to deal with this dilemma by forming a groundbreaking new entity aptly named JIAC -- the Jefferson Industry Advisory Council. Under the leadership of Dr. Geno Merli, the Ludwig Kind Professor of Medicine and Senior Associate Dean for CME, Dr. Richard Wender, the Alumni Professor and Chairman of the Department of Family Medicine and Chairman of the Jefferson Medical College CME Committee, and the Office of Health Policy and Clinical Outcomes, the JIAC has completed two meetings over the last year. The goal of JIAC is to serve as a forum in which representatives from across Thomas Jefferson University can meet with multiple pharmaceutical companies and explore ways we might work together more effectively within current environmental constraints.

Ultimately, there is congruence in our thinking as the industry and JMC wish to create outstanding educational programs for all of our clinicians. JIAC has called for multi- and inter-disciplinary educational programming, the reduction of medical error, and the maintenance of a proper balance in the content of all professional educational programming on our campus. Without an appropriate dialog, there can be no progress. What have we learned from our JIAC experience thus far?

Surprisingly, we have learned that representatives from more than 50 different pharmaceutical companies have urged us to work together with them to more clearly delineate our educational goals and to explicitly separate those goals from the marketing function of the industry. Industry representatives are deeply interested in measuring a return on investment (ROI) for their support of CME. This ROI is not linked to an increase in the number of prescriptions written but, rather, new tools and techniques to measure the outcomes of educational programming. Frankly, this is very much in line with recent curriculum requirements from the Accreditation Council for Graduation Medical Education (ACGME), which have been described in detail in this space previously ("ACGME Competencies: The Curricular Challenge," *Health Policy Newsletter* editorial, December 2002). Industry representatives would like us to make more effective use of the Internet as a training tool and offered detailed suggestions as to how we might operationalize such programs. They urged us to create a repository of enduring CME materials easily accessible and not linked to any one sponsor. They invited us to participate in the actual training of the field representatives in order that they may better understand the role of certain specialists and the team approach to patient care. They challenged us to provide better research comparing the economic ramifications of new technologies. Detailed summaries of the JIAC proceedings are available through the JMC Office of Continuing Medical Education.

In the final analysis, I believe that some of the recent media attention to these perceived conflicts of interest regarding our relationship with the pharmaceutical industry comes as a toxic byproduct of other corporate malfeasance in the likes of Enron, WorldCom, and others. These concerns transcend the United States, as there is considerable international interest in comparable issues well described in a recent article in the *British Medical Journal*.⁷

Personally, I do not believe that we should cancel all pharmaceutical-sponsored activities within medical schools or even prohibit the distribution of pens and pads! I am committed to finding that middle ground where we can work together to better understand how new agents diffuse into practice. I support educational research to find better outcome measures of our work together. Simply cataloging a change in physician attitudes or tracking script-writing behavior is insufficient for the 21st century. While we may be loath to admit it, the pharmaceutical industry has decades of experience in influencing and changing physician behavior. Perhaps there is something we can harness here that will serve our own needs with regard to the standardization of care, quality measurement and improvement, and error reduction. The publication of additional weighty "Codes of Conduct" are important, but additional pronouncements will not provide us with the operational framework, like JIAC, to move forward. Provocative? Surely. Pragmatic? I hope so. As usual, I am interested in your views. You can contact me at my e-mail address: david.nash@jefferson.edu.

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